

## Workers' Compensation Diagnosis Update

**Please return completed application to the applicable entity regarding this claim.**  
*(Private Carrier, Self-Insured, or Third Party Administrator (TPA) administering this claim)*

**Instructions:** This form is intended for use by the physician of record to update appropriate diagnostic information. Complete claimant and physician information. List ICD9-CM codes in order of severity with corresponding descriptions. Show clinical findings upon which the diagnosis is based. **Sign and date the form and mail to the private carrier, self-insured, or the TPA administering this claim.**

1. Claimant Name:	2. Claim Number:	3. Social Security Number: ____ / ____ / _____	4. Date of Injury: ____ / ____ / ____
5. Treating Physician Name and Address: _____ _____ _____ _____		6. ICD9-CM Diagnosis Numerical Code(s): 1. Primary: _____ 2. Secondary: _____ 3. Secondary: _____ 4. Secondary: _____	
7. Physician's FEIN: _____			
8. Diagnosis Description: 1. Primary: _____ 2. Secondary: _____ 3. Secondary: _____ 4. Secondary: _____			
9. Provide clinical findings on which current diagnosis is based and advise how the present condition relates to the compensable injury. _____ _____ _____ _____ _____ _____ _____ _____			
10. Physician Signature _____		11. Date _____	